Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HIGH POINT PHARMACY

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-05-A738-01

Carrier's Austin Representative Box
Box Number 5

MFDR Date Received
July 25, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the manufacturer of the EBI Ice Machine, the correct HCPCS Code to use is E1399 as there is no other available HCPCS code that is descriptive of the EBI Ice Machine. The TWCC guidelines allow for use of HCPCS E1399 miscellaneous code when no other descriptive coding is available providing that an adequate description is given of the product. We have provided a detailed description of the EBI Ice Machine and have billed our usual and customary rate. Additionally, we have provided the Carrier with examples of audit sheets and/or copies of checks where other carriers in this area have established the $495.00 charge for the EBI Ice Machine as a fair and reasonable amount as the Commission has not established a MAR for this procedure."

Amount in Dispute: $495.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In response to the denial of the CPT code E1399 billed for date of service 12/30/04 for the EBI Ice Machine Cold Therapy Unit, we are sustaining the denial and standing on our position that the provider should rebill using a proper HCPCS code. There is a HCPCS code that is comparative to the item billed that the provider could possibly use if the find that that it describes the product that they are billing for, which is E0218 (Water Circulating Cold Pad with Pump)."

Response Submitted by: Kristi A. Davis, Medical Bill Repricing, St. Paul Travelers, 1301 E. Collins Blvd., Richardson, Texas 75081

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 30, 2004	EBI Ice Machine Cold Therapy Unit	$495.00	$495.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The requestor submitted an amended Table of Disputed Services dated July 26, 2006. The Division will consider the remaining disputed services as indicated in the requestor's amended table as the basis for this review. The amount in dispute will be deemed to be the amount as listed on the requestor's revised table.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - TR21 – 16 – CLAIM/SERVICE LACKS INFORMATION NEEDED FOR ADJUDICATION. ADD'L INFO IS SUPPLIED IN REMITTANCE ADVICE CODES WHEN APPROPRIATE. THE F/S DOES NOT ALLOW REIMBURSEMENT FOR NON-VALID CODES. PLEASE RESUBMIT W/CORRECT CPT CODE.
   - DUPQ – D – THESE SERVICES HAVE ALREADY BEEN CONSIDERED FOR REIMBURSEMENT.

Findings

1. The insurance carrier denied disputed services with reason codes TR21 – "16 – CLAIM/SERVICE LACKS INFORMATION NEEDED FOR ADJUDICATION. ADD'L INFO IS SUPPLIED IN REMITTANCE ADVICE CODES WHEN APPROPRIATE. THE F/S DOES NOT ALLOW REIMBURSEMENT FOR NON-VALID CODES. PLEASE RESUBMIT W/CORRECT CPT CODE."; and DUPQ – "D – THESE SERVICES HAVE ALREADY BEEN CONSIDERED FOR REIMBURSEMENT." Review of submitted documentation finds that the procedure code billed by the health care provider, E1399, was a valid procedure code on the date of service. Although Medicare does not establish a reimbursement value for items billed under this miscellaneous HCPCS code, the code was effective on the date of service and is a proper code for reporting items with no assigned code. The respondent argues that "There is a HCPCS code that is comparative to the item billed that the provider could possibly use if the find that that it describes the product that they are billing for, which is E0218 (Water Circulating Cold Pad with Pump)." However, the description of the disputed item does not match the description of the code given by the respondent; moreover, the respondent presented no documentation to support the argument that E0218 is an accurate or required code. Conversely, the requestor presented compelling documentation to support that E1399 is a proper code for reporting the disputed item. Based on the preponderance of the evidence, the Division concludes that E1399 is an appropriate code for billing the disputed item. Accordingly, the insurance carrier's denial reasons are not supported. The disputed item will therefore be reviewed for reimbursement according to applicable Division rules and fee guidelines.
2. Procedure code E1399 represents durable medical equipment for which neither CMS nor the Division had established a relative value or payment amount at the time of service. Per 28 Texas Administrative Code §134.202(c)(6), "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." No documentation was found to support that the insurance carrier has assigned a relative value or payment amount for this disputed service. The Division concludes that the insurance carrier has not met the requirements of §134.202(c)(6). Consequently, reimbursement is determined according to the provisions of 28 Texas Administrative Code §134.1, regarding use of the fee guidelines.
3. This dispute relates to durable medical equipment with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) states that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor's position statement asserts that "we have provided the Carrier with examples of audit sheets and/or copies of checks where other carriers in this area have established the $495.00 charge for the EBI Ice Machine as a fair and reasonable amount as the Commission has not established a MAR for this procedure."
- In support of the requested reimbursement, the requestor submitted nine redacted explanations of benefits from various sample insurance carriers, along with redacted copies of the original bills, sufficient to establish that the sample insurance carriers reimbursed the health care provider an amount of $495.00 for the same or similar EBI Ice Machines provided to patients under similar circumstances and billed under procedure code E1399.
- The Division finds that the requested reimbursement would not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf.
- In considering the increased security of payment afforded by the Act, the Division concludes that the requested reimbursement would be fair and reasonable, ensure the quality of medical care, and achieve effective medical cost control. Accordingly, the requestor has supported that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is supported. Thorough review of the submitted documentation finds that the requestor has discussed, demonstrated, and justified that $495.00 is a fair and reasonable rate of reimbursement for the EBI Ice Machine in dispute.

6. 28 Texas Administrative Code §133.307(j)(1)(E)(iii), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include a statement of the disputed fee issue(s), which includes "a discussion of how the Texas Labor Code and commission rules, including fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the respondent has not discussed how the Texas Labor Code and commission rules, including fee guidelines, impact the disputed fee issues. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(E)(iii).
7. 28 Texas Administrative Code §133.307(j)(1)(E)(iv), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include a statement of the disputed fee issue(s), which includes "a discussion regarding how the submitted documentation supports the respondent position for each disputed fee issue." Review of the submitted documentation finds that the respondent has not discussed how the submitted documentation supports the respondent position for each disputed fee issue. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(E)(iv).
8. 28 Texas Administrative Code §133.307(j)(1)(F), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code §413.011 and §§133.1 and 134.1 of this title." Review of the submitted documentation finds that:
   - The respondent has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The respondent did not discuss or explain how the amount paid represents a fair and reasonable reimbursement for the EBI Ice Machine.
   - The respondent did not present documentation of nationally recognized published relative value studies, published commission medical dispute decisions, or values assigned for services involving similar work and resource commitments to support a specific reimbursement amount.
   - The respondent did not submit documentation to support that the amount paid is a fair and reasonable rate of reimbursement for the item in dispute.
   - The respondent did not explain how the amount paid satisfies the requirements of 28 Texas Administrative Code §134.1.

   The respondent's position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the health care in dispute. The Division concludes that the respondent has not met the requirements of 28 Texas Administrative Code §133.307(j)(1)(F).
9. The Division concludes that the documentation submitted in support of the payment amount proposed by the requestor is the best evidence of an amount that will achieve a fair and reasonable reimbursement for the item in dispute. By a preponderance of the evidence, the requestor has established that $495.00 is a fair and reasonable payment for the disputed EBI Ice Machine. This amount is recommended. The insurance carrier has paid $0.00, leaving a balance due to the requestor of $495.00.

Conclusion

After thorough review and consideration of the evidence presented by the parties to this dispute, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $495.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $495.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	April 17, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.